conjunction with stroke, which is physiologically associated with heart disease in that they are both cardiovascular diseases. As the totality of cardiovascular diseases (whose underlying components are hypertension and arteriosclerosis) continues to be numerically more important than cancer, it is not clear what focusing on the fractional distinction between the two chronic diseases accomplishes from any policy standpoint.

In addition, it is not evident that the causes of death dominating the younger populations provide greater potential for preventive actions compared with chronic diseases in the older populations. Indeed, preventive efforts regarding tobacco control, alcohol, weight management, and environmental pollution have been beneficial in curtailing mortality—and expanding life expectancy—for chronic diseases in the older population. By contrast, the causes of death more common in younger industrialized country populations, heavily beset by mental and behavioral disorders (anxiety, depression, alcohol and opioid abuse) have proven more intractable to preventive measures.[7]

EQUALITY IN HEALTH RESOURCE ALLOCATION

In the current US political climate, with impending legislation proposing major reductions in health insurance, the use of YLL legitimates further devaluation of older and less healthy populations. But the overriding ethical principle of public health must specify that all persons are of equal worth and are to be treated equally over the life span, taking into account their need for health and preventive services on the basis of illness severity and potential mortality. AJPH

M. Harvey Brenner, PhD

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On Being Transnational and Transgender: Human Rights and Public Health Considerations

See also Cheney et al., p. 1646.

There has been a notable increase in attention to the lives and health needs of transgender people.[1,2] The growing burden of HIV among transgender communities during the 1990s brought visibility to this population, spurring two decades of research on individual-level health behaviors, mental health, substance use, and sex work as drivers of transgender women's HIV risk.[3] The Institute of Medicine called for a broader research agenda on transgender-specific health needs in 2011—the same year that the National Transgender Discrimination Survey highlighted systematic antitransgender bias and structural violence as enduring challenges for transgender people.[4] The human rights of transgender people have more recently been garnering attention as a legitimate public health issue, demonstrated by the study by Cheney et al. (p. 1646), in this issue of *AJPH*, on transgender women from Mexico seeking asylum in the United States. This work demonstrates how the arc of research on transgender health has evolved from initially focusing on individual-level behaviors to considering transnational and legal issues that affect health outcomes.

The study analyzed asylum declarations filed through a legal service organization in California by transgender women immigrating from Mexico. Although Mexico has instituted national policies that acknowledge the rights of sexual minority populations, such as the legalization of same-sex marriage, there remains resistance to progress among religious institutions and local communities that acknowledge only heterosexual lifestyles and that discriminate against nontraditional forms of gender identity and expression. According to their document analysis, systemic community violence was a key impetus for transgender women's immigration from Mexico.

Forms of violence included childhood insults by family members, intimidation in school settings, and more extreme acts of physical victimization, sexual assault, and murder of transgender adults. Transgender women reported a lack of support from police and the legal system in Mexico; some officers were perpetrators of transgender violence. The authors noted limitations of their research, including a nonrepresentative sample of transgender women from Mexico who had access and comfort using legal services in the United States, which might not be the case for many transgender immigrants.

ABOUT THE AUTHORS

Don Operario is with the School of Public Health, Brown University, Providence, RI. Tooru Nemoto is with the Public Health Institute, Oakland, CA.

Correspondence should be sent to Don Operario, Brown University School of Public Health, 121 South Main St., Providence, RI, 02912 (e-mail: Don_Operario@brown.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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Violence and other human rights violations among transgender people are not geographically unique. Findings reported in the National Transgender Discrimination Survey revealed the "banality" of violence in transgender communities in the United States,[4] and our research findings have documented the prevalence and health correlates of antitransgender violence in the United States[5] and throughout the Global South.[3] For example, research with transgender women in Thailand (known locally as *kathoey*) reported violence inflicted by family members (generally fathers and brothers) while participants were questioning their gender and expressing nonnormative gender traits.[6] In Malaysia, transgender women (known locally as *mak nyah*) are frequently exposed to physical violence and harassment from police and religious authorities, and the systematic employment discrimination of *mak nyah* can lead to survival sex and an elevated risk of trauma, exposure to violence, HIV, sexually transmitted infections, and substance abuse.[7]

Many transgender women immigrants and asylum seekers bring a history of violence and trauma with them as they resettle in the United States. Consequently, they may avoid institutions that require disclosure of their gender history, such as health care and legal support agencies, to protect themselves against the antitransgender stigma that has been well documented in the United States. Unhealthy trajectories may continue in the United States for transgender immigrants because of the intersection of antitransgender bias, anti-immigrant bias, and racism and because of health systems that traditionally have a myopic view on individual-level determinants of health.

We urge public health researchers and providers to contextualize the health needs of transgender immigrants within a transnational and human rights backdrop. Individual-focused health interventions, guided by individual-level theories and frameworks, may have limited success without recognition of the structural and life course challenges that transgender immigrants experienced before, during, and after their migration to the United States. Future study must address transgender immigrants' and asylum seekers' access to and utilization of health and social service in the United States in relation to their cumulative exposure to antitransgender discrimination, violence, and trauma. Transnational public health and policy efforts are necessary to advance the human rights of transgender people globally and must promote basic safety, freedom of expression, freedom from violence, and access to legal protections as foundations for public health for transgender people. AJPH

Don Operario, PhD
Tooru Nemoto, PhD

CONTRIBUTORS
Both authors contributed equally to this article.

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Can Population Health Science Counter In-Kind Dangerous Oversimplifications? A Public Health of Consequence, October 2017

See also Nestadt, p. 1548; Taksler and Rothberg, p. 1653; and Cheney, p. 1646.

We are living in an era of triumphant compelling simplification. It is not too far a stretch to suggest that the federal election that brought President Donald J. Trump to power rested on large swaths of the population believing the statements made by candidate Trump that were oversimplifications of complicated truths. Candidate Trump suggested that building a wall would limit immigration from Mexico, eliding sober assessments that, historically, walls have rarely been a good long-term solution, that such a wall would make very little difference on immigration, and that over the past few years, there have been more Mexicans leaving the United States than coming to the United States.[1] And yet, Trump built a successful presidential campaign by constructing a compelling notion that a wall would be a solution to a nonproblem.

Trump's victory has been attributed, in part, to his mastery

ABOUT THE AUTHORS
Sandro Galea is dean and professor, School of Public Health, Boston University, Boston, MA. Roger D. Vaughan is a biostatistician and an AJPH *associate editor.*

Correspondence should be sent to Roger D. Vaughan, DrPH, MS, American Public Health Association, 800 I Street NW, Washington, DC 20001 (e-mail: roger.vaughan@columbia.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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